IN THE COURT OF APPEALS OF TENNESSEE
AT NASHVILLE
April 27, 2006 Session

PHEBE M. WATERMAN v. PETER HELGE DAMP, M.D., ET AL.

Appeal from the Circuit Court for Davidson County
No. 03C-571 Hamilton V. Gayden, Judge

No. M2005-01265-COA-R3-CV - Filed on October 9, 2006

This appeal comes from the trial court's summary judgment grant in favor of the defendants in a malpractice case. The appellant challenges the trial court's finding that, since the experts she proffered did not offer satisfactory testimony on the statutory "locality rule," she failed to present a *prima facie* case under the state's malpractice statute. *See* Tenn. Code Ann. §29-26-115. We hold that, despite the infirmities in the plaintiff's proffered experts, the deposition testimony of the defendant doctor was sufficient to demonstrate a genuine issue of material fact as to the standard of care, and the affidavit of the plaintiff's expert Dr. Childs was sufficient proof of causation to preclude summary judgment. Therefore, the grant of summary judgment in favor of the defendant doctor is reversed. We also conclude that the undisputed facts in the record demonstrate that the summary judgment in favor of the defendant hospital was appropriate and affirm that portion of the trial court's ruling. The judgment of the trial court is affirmed in part, reversed in part and remanded for trial on the merits as to the claim against the defendant doctor.

Tenn. R. App. P. 3 Appeal as of Right; Judgment of the Circuit Court Affirmed in Part, Reversed in Part and Remanded

WILLIAM B. CAIN, J., delivered the opinion of the court, in which WILLIAM C. KOCH, JR., P.J., M.S., and FRANK G. CLEMENT, JR., J., joined.

Richard L. Duncan and Cary L. Bauer, Knoxville, Tennessee, for the appellant, Phebe M. Waterman.

Wendy Lynne Longmire and Julie Bhattacharya, Nashville, Tennessee, for the appellee, Peter H. Damp, M.D.

Mary Martin Schaffner, Nashville, Tennessee, for the appellee, St. Thomas Hospital.

OPINION

I. THE INJURY

On May 16, 2002, Plaintiff Phebe Waterman was transported to St. Thomas Hospital's ("St. Thomas") emergency room by ambulance after a small tree fell on her. She was treated by Dr. Peter H. Damp who conducted a physical exam and requested x-rays. Dr. Richard B. Stewart, a radiologist, then read the x-rays and noted a possible compression fracture of unknown age at the T5 portion of Ms. Waterman's spine. According to the complaint, Dr. Damp did not inform Ms. Waterman of these findings. He prescribed pain medication and released her. Mrs. Waterman signed the release forms that advised her to return to the hospital's emergency room if her pain increased.

Two days later Ms. Waterman went instead to the Vanderbilt Clinic complaining of increased pain and decreased mobility. She was treated at Vanderbilt on May 18 and 20, 2002. She informed Vanderbilt personnel of her previous St. Thomas visit and told them that x-rays were taken but that no fracture was found. She was again treated and released with pain medication. She did not follow up with an orthopedist until June 3, when she visited Dr. Dave A. Alexander at Tennessee Orthopedic Alliance. Dr. Alexander's notes reveal the following diagnosis:

> I reviewed her x-rays from St. Thomas Hospital at the time of injury. Shoulder x-rays look normal except for some degenerative changes. Thoracic spine x-rays reveal mid-thoracic spine area about T5 or T6 compression fracture (marked by the radiologist at T5).
>
> She asks about possible bracing for her back and though this is certainly possible I would rather get an opinion from one of our experts, Dr. Stahlman. I would like for him to see her and decide whether she may be becoming a candidate for vertebralplasty as I think she might....

Dr. Stahlman saw the plaintiff on June 10, 2002. His notes confirm Dr. Alexander's impression:

> IMPRESSION:
> It is certainly conceivable that [Ms. Waterman] has an acute compression fracture in her thoracic[spine]. However, by x-ray alone, I cannot ascertain the acuity. She could certainly have a rib or sternal injury as well, given the forward compressive force she suffered.
>
> RECOMMENDATIONS:
> I have recommended an MRI of her thoracic and lumbar spine. I have also recommended a bone scan to assess any rib fractures. I have given her a prescription for a Cash orthosis and suggested trying Ultram. I will see her back after her imaging studies are performed.

Dr. Stahlman's notes indicate that by the time the new imaging had been performed, "the vertebral collapse is so great that kyphoplasty or vertebralplasty would be technically unfeasible."

II. THE LAWSUIT

Ms. Waterman brought suit against Dr. Damp and St. Thomas alleging medical malpractice which resulted in physical injury and increased treatment cost. She filed her complaint on May 30, 2003, and made the following specific allegations:

> 6. If Defendants had properly interpreted the x-rays performed on May 16, 2002 and/or immediately referred the plaintiff to an orthopedist within the standards of acceptable professional practice, then to a reasonable degree of medical certainty, Plaintiff's fracture would have been diagnosed as acute and would have been properly treated resulting in a substantially better outcome.
>
> 7. Defendant Dr. Peter Damp, was negligent and/or deviated from the recognized standard of professional practice. Such negligence and/or deviations consisting of, inter alia:
>
> a. Failing to treat Plaintiff's acute compression fracture and/or immediately refer Plaintiff to an orthopedist;
>
> b. Discharging Plaintiff without ordering any bracing devices and immediate referral to an orthopedist;
>
> c. Failing to be adequately trained in the care and treatment of compression fractures of uncertain age;
>
> d. Other Acts of negligence that will be shown at trial.

The Complaint made these same allegations against St. Thomas on principles of vicarious liability. The Complaint further alleged that as a result of this conduct, "Plaintiff now ambulates with a walker which she has been forced to use since the injury. Plaintiff has suffered and continues to suffer severe pain, loss of enjoyment of life, loss of earnings, loss of earning capacity and medical expenses proximately caused by the negligence of the defendants." St. Thomas answered the Complaint on July 15 denying any agency relationship sufficient to trigger vicarious liability. Dr. Damp filed his answer on August 18, 2003, denying any malpractice. The following June, Plaintiff took Dr. Damp's deposition.

A. THE MOTIONS FOR SUMMARY JUDGMENT

In August 2004, Dr. Damp moved for summary judgment. The motion was supported by Dr. Damp's own affidavit averring that his treatment of Ms. Waterman comported with the standard of care for emergency physicians in Nashville, Tennessee and that no breach of the standard on his part proximately caused Ms. Waterman's injuries. He argued that in the absence of proof of the standard, the breach and proximate cause of the alleged injury, under Tennessee Code Annotated section 29-26-115, Plaintiff Waterman had failed to establish a *prima facie* medical malpractice claim. The motion was also accompanied by a statement of undisputed facts filed pursuant to Tennessee Rule of Civil Procedure 56. Of particular import are the following statements:

3. Dr. Damp ordered various x-rays of Plaintiff including her left scapula, [thoracic] spine, and chest.
4. Dr. Richard B. Stewart, a radiologist, interpreted the Plaintiff's x-rays and diagnosed a "moderate compression of T5 of uncertain age" in the Plaintiff's thoracic spine and stated that the Plaintiff had degenerative changes and "likely long-standing" anterior wedging.
5. Upon examination and finding no actual thoracic and lumbar spine tenderness, Dr. Damp prescribed Plaintiff pain medication and released her with the express warning to return to the emergency room upon any worsening, sudden pain or shortness of breath.
6. On her discharge papers document signed by plaintiff, Dr. Damp advised that if the Plaintiff's pain persisted or worsened, she was to ["]return to ER otherwise follow up with primary care physician."
7. Dr. Damp's diagnosis, treatment, testing and management of Plaintiff's condition fell within the acceptable range of professional care rendered by an emergency room physician in the Nashville, Davidson County, Tennessee medical community.
8. There were no acts or omissions on Dr. Damp's behalf that breached the standard of care or that caused or proximately caused injury to the Plaintiff on May 16, 2002 or any day thereafter.

The summary judgment motion was set to be heard on October 8, 2004. Ms. Waterman made no formal response to the summary judgment motion other than filing responses to Dr. Damp's statements of undisputed facts. In these responses filed on October 1, 2004, Ms. Waterman admitted statements 1-3 for purposes of summary judgment and admitted that the medical records cited in statements 4-6 speak for themselves. She denied statements 7-8 and referred to the following portion of Dr. Damp's testimony:

> [BY MR. BAUER]:
> Q. Okay. And you don't feel that an ER doctor in 2002 in Davidson County has an obligation to the patient to inform them of non-acute injuries that they may not be aware of?
> A. I think if they are potentially medically relevant in the future, such as seeing like a lung nodule or something that may be dangerous in the future, yes.
> Q. Okay. What about if you don't know?
> A. It could be.
> Q. Could be the standard of care?
> A. Like I said, it depends on that the – what you don't know.
> Q. Okay. If you don't know for sure the age of a compression fracture at T5 of the spine, is that something that the standard of care would require an ER doctor to inform the patient on?
> A. If you're unsure, yes.

Q. Okay. Does the standard of care require that you tell the patient that I think this is a chronic condition but there's a possibility that it's an acute condition?
A. Possibly, yes.
Q. Okay. Well, is it possible or is it the standard of care?
A. I'd say it is the standard of care.
Q. Okay. Do you recall in this particular case if you told Phebe Waterman anything about a compression fracture in her spine?
A. I honestly do not remember – – if I mentioned if I told her that or not.
Q. If she says she was not told anything about a compression fracture, you would have no way to dispute that then?
A. Since I do not remember that, no.

On the afternoon prior to the summary judgment hearing, Ms. Waterman filed a Motion To Continue The Trial with the affidavit of Dr. Ronald Childs attached. In his affidavit Dr. Childs averred that he was "familiar with the standard of acceptable professional practice of physicians practicing in emergency departments treating orthopaedic injuries in communities medically similar to Davidson County by virtue of receiving numerous patients on referral from emergency department physicians in and around Fairfax County, Virginia." Dr. Childs's affidavit contains the following additional averments:

> The standard of care for a patient like Phebe Waterman required either a consult with an orthopaedist or orthopaedic surgeon at St. Thomas with further diagnostic work-up or immediate referral to an orthopeadist or orthopaedic surgeon for further evaluation and treatment of her compression fracture...
>
> 7. If Dr. Peter Damp had treated Phebe Waterman within the recognized standard of care, he would have either obtained a consult from an orthopaedist or orthopaedic surgeon at St. Thomas Hospital or he would have immediately referred Phebe Waterman for further evaluation and treatment of her compression fractures. Earlier diagnosis would have allowed for treatment options such as vertebroplasty, kyphoplasty, and/or bracing designed to prevent collapse. If Phebe Waterman had received earlier appropriate treatment, then more likely than not, she would have had a substantially better outcome with greater mobility and less pain.

Waterman's counsel withdrew the Motion To Continue during the hearing on summary judgment. After a hearing, the trial court entered its order of November 3, 2004, containing the following findings:

> Upon pleadings filed and argument of counsel, the Court took the Defendant's Motion for Summary Judgment under advisement, and ordered the parties to attend a Scheduling Conference before Candy Rucker on October 25, 2004.

Further, the Court opined that an orthopaedic surgeon may not be able to address the standard of care of an emergency room physician in Davidson County, and will permit the Plaintiff additional time, up to six (6) months, to file the expert depositions of additional experts. Finally, the Court assessed a $350.00 sanction for attorneys' fees against the Plaintiff's attorney, to be applied or to be taken out of any settlement or judgment for failure of the Plaintiff to timely respond to the Motion for Summary Judgment.

B. ADDITIONAL EXPERT PROOF

During the period in which the court had taken Dr. Damp's motion under advisement, St. Thomas Hospital filed its Motion For Summary Judgment in March of 2005. Ms. Waterman then obtained the services of Dr. Kathryn Easterling whose discovery deposition was taken on April 1, 2005. In that deposition, Dr. Easterling testified that she currently worked part-time in Clayton Georgia, a town whose population she estimated at 2,000 people. She worked at the Rabun County Hospital, a "critical access" hospital utilizing between 25 and 49 beds. Until medical problems two years prior to the deposition, she had worked full-time at Rabun County Hospital and its predecessor Ridgecrest Hospital. She testified that as a patient she had undergone surgery in the Atlanta area, as well as in Boston, Massachusetts, in Massachusetts General Hospital. In her deposition she was called upon to give her expert opinion as to the standard of care applicable to emergency room physicians in a community similar to the Metropolitan Nashville and Davidson County community. Under examination by counsel for Dr. Damp regarding her familiarity with the standard of care, the following exchanges occurred:

Q. Okay. And is it your testimony that you are familiar with the standard of care in Nashville, Tennessee?
A. Yes.
...
Q. All right. But what's the basis for your opinion that you are familiar with the standard of care in Nashville?
A. Well, you know, I worked in a hospital that was in similar size, and the standard of care in Clayton, Georgia - I would expect there to be more facilities to do even more in a larger city like Nashville than Clayton, Georgia.
...
Q. Okay. So are you saying that the basis for your familiarity with the standard of care in Nashville is that you practiced emergency medicine in Clayton, Georgia?
A. And in a larger city similar in size to Nashville.
Q. All right. And are you speaking of Atlanta.
A. Yes.
...
Q. All right. What is – are you familiar with the standard of care in Atlanta, Georgia, with regard to emergency medicine?
A. Yes.

...

Q. All right. Now the last time that you practiced medicine in Atlanta, Georgia, was in 1992?

A. Correct.

Q. And since that time, you have not provided any medical treatment whatsoever in Atlanta, Georgia?

A. No.

...

Q. Okay. And have you made any studies into the medical community in Atlanta, Georgia, or any investigation about that since 1992?

A. What about the medical community?

Q. Anything. Have you made studies or investigation into the medical community, do you have any ties with it in Atlanta, Georgia, in the ast ten years?

A. Not directly, no.

Q. All right. And would you agree that the medical community in Atlanta has changed in the last ten years?

A. It has.

Q. And in 2002, you said that you worked part time on the emergency staff at the – this county hospital that's next to us; is that correct?

A. Correct.

Elsewhere in deposition Dr. Easterling had revealed that her only board certification was in ambulatory medicine:

Q. Okay. Ambulatory medicine. And what is that?

A. Well it's for people that can come to your office.

Q. Much like family practice?

A. Yes, much like family practice.

She testified that she had never held board certification in emergency medicine despite her previous medical practice in an emergency room in Atlanta. Nevertheless, Dr. Easterling provided the following testimony concerning her steps in familiarizing herself with the expert community standards in Nashville:

Q. (By Mr. Bauer:) In familiarizing yourself with the standard of care for an ER doctor in 2002 in Davidson County, Nashville, Tennessee, did you review demographic information related to Davidson County, Tennessee and the Davidson County medical community?

A. Yes.

Q. Okay. And as part of that review did you look at the population of Davidson County, Tennessee?

A. Yes.

Dr. Easterling could approximate the number of doctors, hospital beds, medical schools and hospitals providing emergency medicine as well as the "diagnostic modalities" most likely used in these facilities. She opined that the standard of care required Dr. Damp to refer his patient for a consult with an orthopedist or orthopedic surgeon, or at the very least, despite the absence of pain on examination and palpation, inform the patient of a possible acute compression fracture.

C. THE GRANT OF SUMMARY JUDGMENT

Dr. Damp's motion was reset for hearing on April 29, 2005, and the deposition of Dr. Easterling was filed in response. The trial court entered two orders. The order entered on May 10, actually disposed of Dr. Damp's motion, while the May 9 order granted summary judgment to St. Thomas. The May 10 order recites the relevant procedural history:

> The Motion for Summary Judgment filed by Peter Helge Damp, M.D., was originally heard on October 8, 2004. In response to that Motion, Plaintiff filed a Motion for Continuance along with an affidavit of an orthopedic spine surgeon Dr. Ronald Clayton Childs. The Court took the Motion for Summary Judgment under advisement at that time, and allowed the Plaintiff up to six (6) months to file any additional depositions of any experts the Plaintiff selected to oppose the Motion for Summary Judgment. The Defendants then reset the Motion for Friday, April 29, 2005. In the interim, the Plaintiff disclosed one additional physician, M. Kathy Easterling, M.D., of Clayton, Georgia and filed her deposition in its entirety with the Court.
>
> Based upon the argument of counsel, the pleadings filed, the deposition of Dr. M. Kathy Easterling and the Affidavits of Phebe Waterman, Dr. Ronald Clayton Childs, and Dr. Peter Helge Damp, the Court considered Dr. Peter Helge Damp's Motion well taken. The Court ruled that Plaintiff's proposed experts fell short of their competency to testify with regard to standard of care for emergency medicine and the Tennessee locality rule. The Court ruled that the Plaintiff failed to produce competent expert proof to refute Dr. Peter Helge Damp's Motion for Summary Judgment, and, thus, there was no dispute that Dr. Damp complied with the standard of care for emergency room physicians practicing in Nashville or in similar communities. The Court granted Defendant Damp's Motion for Summary Judgment, granted Defendant St. Thomas Hospital's Motion for Summary Judgment with regard to liability based upon the acts or omissions of Dr. Richard Stewart, and dismissed the remainder of Defendant St. Thomas Hospital's Motion for Summary Judgment as moot based upon the Court's ruling regarding Defendant Peter Helge Damp, M.D.'s Motion for Summary Judgment.
>
> It is hereby ORDERED, ADJUDGED and DECREED that the case of Phebe M. Waterman vs. Peter Helge Damp, M.D., shall be and is hereby dismissed in its entirety, with prejudice.

The order entered May 9, 2005 disposed of St. Thomas's motion:

> After hearing statements of counsel and reviewing the record as a whole, the court finds that the plaintiff has conceded Dr. Richard Stewart complied with the applicable standard of care and did not cause her injuries that would not otherwise have occurred. The court is therefore of the opinion that, to the extent plaintiff's claim against St. Thomas Hospital is based upon vicarious liability for Dr. Stewart, this action should be dismissed as to St. Thomas Hospital. The court is further of the opinion that, to the extent plaintiff's claim against St. Thomas Hospital is based upon vicarious liability for Dr. Peter H. Damp, this action should be dismissed as moot, the motion for summary judgment filed on behalf of Dr. Damp having been granted and the action dismissed as to him.

III. THE APPEAL

Ms. Waterman now appeals the grant of summary judgment as to Dr. Damp. Since the language of the May 9, 2005 order indicates that the trial court never reached the merits of Waterman's claim against St. Thomas for vicarious liability of Dr. Damp, that defendant appeared in order to preserve its rights in the event of a remand. We reverse the grant of summary judgment as to Dr. Damp. We affirm the trial court's continuance of the case in order to obtain expert proof and affirm the grant of summary judgment to St. Thomas.

A. THE STANDARD OF REVIEW

Since the appeal comes to us on review of a grant of summary judgment, we afford the trial court no presumption of correctness in its determination that the defendant is entitled to judgment as a matter of law. Our review is *de novo* upon the record. We determine separately, viewing the evidence in a light most favorable to the non-moving party, whether the requirements of Tennessee Rule of Civil Procedure 56 are met. *See Stovall v. Clarke,* 113 S.W.3d 715, 721 (Tenn. 2003); *Webber v. State Farm Mut. Auto. Ins. Co.,*49 S.W.3d 265, 269 (Tenn. 2001). A court's decisions regarding the competency of experts to render testimony are reviewed for an abuse of discretion. *See McDaniel v. CSX Transp., Inc.,* 955 S.W.2d 257, 263 (Tenn.1997). The decision whether or not to grant an extension or continuance likewise rests well within the sound discretion of the trial court. *Moorehead v. State,* 409 S.W.2d 357, 358 (Tenn.1966); *Sanjines v. Ortwein & Assocs., P.C.*, 984 S.W.2d 909 (Tenn.1998). Such a decision will not be overturned on appeal unless such a decision constitutes an abuse of discretion. *See Blake v. Plus Mark, Inc.,* 952 S.W.2d 413, 415 (Tenn.1997). *See also Kenyon v. Handal*, 122 S.W.3d 743, 751 (Tenn.Ct.App.2003). With these standards in mind, we consider the proof offered by Plaintiff in her malpractice claim.

B. THE NECESSITY OF EXPERT PROOF AND THE LOCALITY RULE

Although rooted in the common law actions of negligence and battery, the action of malpractice is guided by Tennessee statute.

> In a malpractice action, the claimant shall have the burden of proving by evidence as provided by subsection (b):
>
> (1) The recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred;
>
> (2) That the defendant acted with less than or failed to act with ordinary and reasonable care in accordance with such standard; and
>
> (3) As a proximate result of the defendant's negligent act or omission, the plaintiff suffered injuries which would not otherwise have occurred.

Tenn. Code Ann. § 29-26-115(a).

As the Tennessee Supreme Court has declared:

> The plain and ordinary language in § 115(a)(1) embraces the so-called "locality rule," which requires that the standard of professional care must be based upon "the community in which the defendant practices or in a similar community." As this Court has said:
>
> > This geographic component to the relevant standard of care evolved out of a recognition that medical customs or practices varied depending on the particular area in which the physician practiced.... Traditionally, the relevant geographic area was strictly defined. The plaintiff was required to introduce evidence concerning the standard of care in the strict locality where the defendant worked.
>
> *Sutphin v. Platt*, 720 S.W.2d 455, 457 (Tenn.1986) (citation omitted). Although the *Sutphin* Court also observed that the phrase "or in a similar community," may reflect a "modern trend towards the national standardization of medical practices," *id.*, it nonetheless clarified the legislative intent and purpose as follows:
>
> > There is an undeniable legitimate state interest in assuring that doctors charged with negligence in this State receive a fair assessment of their conduct in relation to community standards similar to the one in which they practice.

Id. at 458; see also *Cardwell v. Bechtol*, 724 S.W.2d 739, 754 (Tenn.1987).

Robinson v. LeCorps, 83 S.W.3d 718, 723 (Tenn. 2002).

C. ANALYSIS OF THE PLAINTIFF'S PROOF IN LIGHT OF THE NEED FOR EXPERT TESTIMONY AND THE LOCALITY RULE

When faced with a motion for summary judgment, a party must come forward with countervailing evidence or present those portions of the record overlooked by the defendant which demonstrate the existence of a material factual issue. This Court has said:

> Patients faced with their physician's summary judgment motion cannot rest on the allegations in their complaint. Tenn. R. Civ. P. 56.06; *Byrd v. Hall,* 847 S.W.2d 208, 210 (Tenn.1993); *Blocker v. Regional Med. Ctr. at Memphis,* 722 S.W.2d 660, 661 (Tenn.1987). They must demonstrate the existence of triable factual disputes either by (1) pointing to evidence ignored or overlooked by the physician, (2) rehabilitating evidence attacked by the physician, or (3) producing additional evidence establishing the existence of a genuine factual issue. *See McCarley v. West Quality Food Serv.,* 960 S.W.2d 585, 588 (Tenn.1998); *Messer Griesheim Indus., Inc. v. Cryotech of Kingsport, Inc.,* 45 S.W.3d 588, 598 (Tenn.Ct.App.2001). Because the practitioners most often file their summary judgment motions before much discovery has occurred, the only practical alternative available to most patients is to file an expert affidavit contradicting their physician's affidavit.
>
> Patients who are unable to produce an expert affidavit of their own face almost certain dismissal of their complaint because the physician has effectively negated an essential element of their case. Without an opposing expert affidavit, patients cannot demonstrate the existence of a genuine factual dispute regarding whether the physician breached the standard of professional practice in the community. *Mabon v. Jackson-Madison County Gen. Hosp.,* 968 S.W.2d 826, 831 (Tenn.Ct.App.1997).

Kenyon v. Handal, 122 S.W.3d 743, 758 (Tenn. Ct. App. 2003).

In the instances where the plaintiff demonstrates a genuine issue of material fact by pointing to countervailing evidence in the record, summary judgment is not appropriate. *See Byrd v. Hall,* 847 S.W.2d 208, 210 (Tenn. 1993). Where competent expert testimony is conflicting, such a genuine issue exists. *See Moon v. St. Thomas Hosp.,* 983 S.W.2d 225, 230 (Tenn. 1998). Ordinarily, proof of malpractice requires the use of expert testimony concerning the applicable standard of care and the defendant's breach. *See Pullum v. Robinette,* 174 S.W.3d 124, 129 (Tenn.Ct.App.2004) quoting *Robinson v. LeCorps*, 83 S.W.3d 718 (Tenn.2002). *See also Stokes v. Leung,* 651 S.W.2d 704, 705 (Tenn.Ct.App. 1982); *see also German v. Nichopoulos,* 577 S.W.2d 197

(Tenn.Ct.App.1978) (overruled on other grounds by *Seavers v. Methodist Med. Ctr. Of Oak Ridge,* 9 S.W.3d 86 (Tenn. 1999).) Such expert testimony is deemed necessary due to the tendency of such claims to involve "complicated and technical information which is beyond the general knowledge of a lay jury." *Seavers v. Methodist Med. Ctr. Of Oak Ridge,* 9 S.W.3d at 92. (Citing *Baldwin v. Knight*, 569 S.W.2d 450, 456 (Tenn. 1978).) See also *Stokes v. Leung,* 651 S.W.2d at 706. Occasionally, however, such proof comes by way of the defendant himself. *See Abbey v. Jackson,* 483 A.2d 330, 334(D.C. 1984). The need for expert proof is crucial at the summary judgment stage in a lawsuit. *Kenyon v. Handal,* 122 S.W.3d at 758.

The deposition testimony of Dr. Easterling makes clear her inability to assist in the determination of the appropriate standard of care for an emergency room doctor operating in a similar community. She shows no real basis for her statements about the appropriate standard in any emergency room due to her remote emergency room experience. As a result, we find no abuse of discretion in the trial court's refusal to consider that testimony as probative. Likewise, the affidavit of Dr. Childs shows only his familiarity with the standard applicable to an orthopedist operating in a similar community. Relative to the applicable standard of care for an emergency room physician in Nashville, Tennessee, it is Dr. Damp's own deposition testimony that is critical to the survival of Plaintiff's case on summary judgment. Such use by Plaintiff of a defendant doctor's own testimony is appropriate for reasons explained by the Court of Appeals of New York.

> While recognizing the right of a plaintiff in a malpractice action to call as a witness the defendant doctor, the courts of several states have sought to limit the type of questions which the plaintiff may put to him. Specifically, it has been held that a defendant physician may be required to testify to 'facts within his knowledge' that is, 'what (he) actually saw and did' but not as to whether his actions deviated from the accepted standard of medical practice in the community, a matter deemed to call for 'expert opinion'. (*Hull v. Plume,* 131 N.J.L. 511, 516-517, 37 A.2d 53; *see, also, Osborn v. Carey,* 24 Idaho 158, 168, 132 P. 967; *Hunder v. Rindlaub,* 61 N.D. 389, 406-410, 237 N.W. 915; *Forthofer v. Arnold,* 60 Ohio App. 436, 441-442, 21 N.E.2d 869; *cf. Ericksen v. Wilson,* 266 Minn. 401, 123 N.W.2d 687.) Other courts, however, permit the plaintiff to examine his doctor-opponent as freely and fully as he could any other qualified witness. (*See Lawless v. Calaway,* 24 Cal.2d 81, 90-91, 147 P.2d 604; *State for Use of Miles v. Brainin,* 224 Md. 156, 167 A.2d 117, 88 A.L.R.2d 1178; *cf.* Snyder v. Pantaleo, 143 Conn. 290, 122 A.2d 21.)
>
> The latter decisions strike us as the more enlightened. That the defendant is an 'expert' and that the particular questions asked of him are those which only an expert can answer, seem beside the point. It is at least arguable that the doctor's knowledge of the proper medical practice and his possible awareness of his deviation from that standard in the particular case are, in a real sense, as much matters of 'fact' as are the diagnosis and examination he made or the treatment upon which he settled. More importantly, however, by allowing the plaintiff to examine the defendant doctor with regard to the standard of skill and care ordinarily exercised by physicians in the

> community under like circumstances and with regard to whether his conduct conformed thereto, even though such questions call for the expression of an expert opinion, the courts do no more than conform to the obvious purpose underlying the adverse-party-witness rule. That purpose, of course, 'is to permit the production in each case of all pertinent and relevant evidence that is available from the parties to the action'. (*State for Use of Miles v. Brainin*, 224 Md. 156, 161, 167 A.2d 117, 119, *supra*; *see, also, Lawless v. Calaway*, 24 Cal.2d 81, 90, 147 P.2d 604, *supra*.) The issue whether the defendant doctor deviated from the proper and approved practice customarily adopted by physicians practicing in the community is assuredly 'pertinent and relevant' to a malpractice action. Indeed, absent such proof, the plaintiff's case would have to be dismissed. Moreover, evidence on this issue is, in most instances, 'available' from the defendant doctor.
>
> The importance of enabling the plaintiff to take the testimony of the defendant doctor as to both 'fact' and 'opinion' is accentuated by recognition of the difficulty inherent in securing 'independent' expert witnesses. It is not always a simple matter to have one expert, a doctor in this case, condemn in open court the practice of another, particularly if the latter is a leader in his field. In consequence, the plaintiff's only recourse in many cases may be to question the defendant doctor as an expert in the hope that he will thereby be able to establish his malpractice claim.

McDermott v. Manhattan Eye, Ear & Throat Hospital et al., 203 N.E.2d 469, 473-4 (NY 1964).

1. The Duty to Refer as a Part of the Standard of Care

In order to survive a motion for summary judgment, a plaintiff suing for malpractice must show a breach of the applicable standard of care which proximately causes injury. Tenn. Code Ann. 29-26-115. On appeal, Ms. Waterman asserts Doctor Damp's duty to refer her to an orthopedic specialist. Indeed the excluded affidavit of Dr. Childs indicates that the failure to refer Ms. Waterman prevented a "substantially better outcome with greater mobility and less pain." The threshold question to be answered, however, is whether the proof presented by the plaintiff, when viewed in the light most favorable to her, demonstrates a genuine issue of material fact as to whether Dr. Damp's duty to treat the plaintiff included a duty to refer her to an orthopedist.

In recognizing generally such a duty, this Court held:

> [A]s a part of the requirements which the law exacts of general practitioners of medicine and surgery, or other schools of healing, if, in the exercise of the care and skill demanded by those requirements, such a practitioner discovers, or should know or discover, that the patient's ailment is beyond his knowledge or technical skill, or ability or capacity to treat with a likelihood of reasonable success, he is under a duty

> to disclose the situation to his patient, or advise him of the necessity of other or different treatment.

Osborne v. Frazor, 425 S.W.2d 768, 773-4 (Tenn. Ct. App. 1968). (Quoting *H.D.W., Annotation, Duty of Physician or Surgeon to Advise Patient of the Possibility or Probability of Better Results from Treatment by Specialist or by a Mode of Treatment Which He is Not Qualified to Give,* 132 ALR 392(1941) (Superseded by *Jerald J. Director, J.D., Annotation, Malpractice: Physician's Failure to Advise Patient to Consult Specialist or One Qualified in a Method of Treatment which the Physician is Not Qualified to Give,* 35 ALR3d 349(1971).)

This Court has asserted:

> Whether there is a duty owed by one person to another is a question of law to be decided by the court. However, once a duty is established, the scope of the duty or the standard of care is a question of fact to be decided by the trier of fact.

Dooley v. Everett, 805 S.W.2d 380, 384 (Tenn.Ct.App.1990).

The scope of the duty to refer recognized in *Osborne v. Frazor* raised other questions which must be answered. What standards must be applied in determining the effect of a failure to refer? Who is qualified to testify as to the effect of a failure to refer? How is causation established?

2. Measuring the Breach

If, under the facts of the case, the scope of a physician's duty includes a duty to refer, there must be some mechanism within the law by which a failure to refer may be measured. In *Osborne*, 425 S.W.2d 768, Plaintiff suffered a broken hip and was taken to the office of the defendant, a general practitioner. She was then admitted to the hospital and surgery was performed by a specialist who was assisted by the defendant. A year later she was readmitted to the hospital for additional hip surgery during which a surgical sponge was left in her hip. For several years thereafter, the undetected sponge produced pain, foul odor and drainage at the surgery site until a few threads of the sponge began to protrude from the wound. The sponge was thereupon removed, and the wound properly healed. The orthopedic specialist who had performed the initial operation on Mrs. Frazor testified:

> Q. If Dr. Osborne testified that he insisted that Mrs. Frazor return to your office for additional examinations and so forth, and that he repeatedly told her that he could not take care of her hip but that he was only taking care of other ailments she had and that she should return to you, is that proper and reasonable care?
>
> A. Yes.

* * * * * * * * * * *

Q. I"ll ask you in your opinion as a specialist, an orthopaedic specialist, are you familiar with the skill and knowledge of the average general practitioner in the town of Hendersonville?

A. Yes.

Q. Do you think it would have been proper that Dr. Osborne probe or go into the wound that you were caring for on Mrs. Frazor?

A. Well, I stated this before in a deposition in my office, and my feeling about the matter is that I would prefer that he would send the patient back to me since it was my case. Some general practitioners are, I should say, bolder than others; but if one of my patients had a draining sinus and if it didn't clear up in a reasonable period of time, I would have preferred that the patient be sent back to me rather than have the general practitioner operate on the patient in any way.

Q. Doctor, as Doctor Osborne visited this lady as a general practitioner, should he have discovered that gauze on the visits that he made?

A. Well, that's kind of putting me on the spot. As I said, when a physician sees a draining sinus, he suspects infection or foreign body. * * *

425 S.W.2d at 772.

The defendant, Doctor Osborne, testified:

I had not been trained in major orthopaedic surgery; knew nothing about it, and certainly never attempt to do something in my medical practice that I have no training for.

* * * * * * * * * * *

Q. According to your memory did you call Dr. Eyler about this?

A. I did.

Q. Did you insist that she go back for the care of her hip to Dr. Eyler?

A. I certainly did.

Q. Did you tell that to the family?

My diagnosis was osteomyelitis, which is infected bone.

* * * Certainly there would be no reason to take a culture on that because you do not cure osteomyelitis with antibiotics. It's a surgical procedure * * * major surgical procedure, not to be done in the home.

I might dress the wound if I had sterile supplies in my bag. * * * but I never at any time assumed care of the hip or even intimated to them that I was caring for the hip. At all times I referred them * * * that this was Dr. Eyler's field, and that Dr. Eyler was treating it, and to get in touch with Dr. Eyler.

* * * * * * * * * * *

* * * When I'd see the wound still draining, I'd urge them again to see Dr. Eyler about it.

Q. Now, let me ask you this. After you'd go out there and find this hip condition that everybody has testified about, would you then call Dr. Eyler and take it up with him and say, "This lady needs * * *."

A. I did several times.

* * * * * * * * * * *

Q. And that's what he would do when you would call about her?

A. Yeah. Say, "Send her in". * * * It must have been half a dozen times.

425 S.W.2d at 772-73.

Dr. Eyler, the orthopedic specialist who performed the initial hip surgery, testified, however:

Q. * * * During that ten year period would you examine your notes and see whether they reflect that Dr. Osborne called you about this lady's hip condition? Did I have you do that on the deposition? If I did, you can save yourself some time.

A. The answer is no.

425 S.W.2d at 773.

It was in the context of such testimony that the duty to refer was analyzed, and the jury verdict for the plaintiff was affirmed.

The duty to refer question is discussed at length in *Larsen v. Yelle*, 246 N.W.2d 841 (Minn.1976). Said the Supreme Court of Minnesota:

> Plaintiff's primary theory of the case was as follows: (1) When confronted with a fracture of the type sustained by plaintiff in the case at bar, the standard of care required of a general practitioner like Dr. Yelle is that he refer the patient to an orthopedic surgeon rather than attempt treatment himself, (2) Dr. Yelle deviated from this standard by failing to refer the case to an orthopedic surgeon and instead undertaking to treat it himself, and (3) plaintiff was injured by Dr. Yelle's deviation from the requisite standard. It is true that one of the requirements which the law exacts of general practitioners of medicine is that if, in the exercise of the care and skill demanded by those requirements, such a practitioner discovers, or should know or discover, that the patient's ailment is beyond his knowledge or technical skill, or ability or capacity to treat with a likelihood of reasonable success, he is under a duty to disclose the situation to his patient, or to advise him of the necessity of other or different treatment. *See, Manion v. Tweedy*, 257 Minn. 59, 65, 100 N.W.2d 124, 128 (1959). If under such circumstances the general practitioner fails to inform the patient and undertakes to treat when he should refer to a specialist, he will be held to that standard of care required of the specialist. That is, in order to escape liability for injury caused by his treatment, the treatment he himself administers to the patient must at a minimum comply with that degree of skill, care, knowledge, and attention ordinarily possessed and exercised by specialists in good standing under like circumstances.
>
> It is important to note, however, that the mere breach of duty to refer a patient to a specialist for treatment will not of itself make out a prima facie case of negligence against the general practitioner. This is so because the treatment which the general practitioner administers may in fact be the exact treatment which a specialist in good standing would have employed had the case been referred to him, and in that circumstance the general practitioner would be no more liable for injury resulting from the treatment than would be the specialist had he administered the treatment. It must appear that the breach of the duty to refer to a specialist in fact caused the plaintiff's injury, and this can be shown only if the treatment the plaintiff received was in some way inferior to the treatment he would have received from a specialist. Thus, in order to make out a case of negligence based on a breach of a duty to refer a patient to a specialist for treatment, the plaintiff must also present evidence from which the trier of fact may determine that in the treatment which he in fact administered, the defendant failed to exercise that degree of skill, care, knowledge, and attention ordinarily possessed and exercised by specialists in good standing under like circumstances.

Larsen, 246 N.W.2d at 844-45. *See also Schmitz Admin. v. Blanchard Valley OB-GYN, Inc.*, 580 N.E.2d 55 (Ohio Ct. App.1989).

On the surface, the *Larsen* rule seems harsh; but, on careful reflection, it is hard to imagine an alternative rule that would not render the duty to refer meaningless. The duty to refer under proper circumstances is clear, and the consequences of failure to refer must be adjudged by some standards. What other standards can there be other than the standards applicable to the physician to whom the referral is made?

Reasonable minds could find from the testimony of Dr. Damp that if the fracture disclosed by the May 16 x-ray of the T-5 portion of Mrs. Waterman's spine was in fact longstanding and chronic, it would not have presented a serious problem. If, however, this fracture was acute or it could not be determined at that point whether it was acute or chronic, the scope of the doctor's duty included the duty to refer.

3. Proving Causation

On the issue of causation, *Merriman v. Toothaker*, 515 P.2d 509 (Wash.App.1973) is analogous to the case at bar. Dr. Toothaker, a pediatrics specialist was on emergency call at Centralia Hospital when Plaintiff was admitted after suffering injuries from an automobile wreck. Toothaker reviewed the x-rays and was unable to detect any sign of bony injury and concluded that Plaintiff suffered a sprained neck. The next day, Plaintiff was discharged with instructions to return home and get ample rest. X-rays taken upon admission to the emergency room were then reviewed by a radiologist who concluded that Plaintiff suffered "anterior compressions at C-5 and C-6 with local kyphosis – which means curving, and ligament damage dorsally permitting widening of the C-5 and C-6 posterior articulations. No abnormality at dorsal levels."

Dr. Toothaker testified that he immediately sent this report to Dr. Hogberg, who was Plaintiff's regular physician. Dr. Hogberg testified he never received such communication from Dr. Toothaker and that when he saw the plaintiff three days after his emergency room experience, Dr. Hogberg was informed that x-rays taken at Centralia revealed no fractures. He testified, "I let it go at that" and sent Plaintiff home with instructions to return two days later and have his stitches removed. The only treatment he received during the next two weeks were neck massages performed by his stepmother. On March 11, 1968, sixteen days subsequent to his emergency room treatment, a noticeable swelling developed in his lower neck region, and Dr. Hogberg immediately hospitalized him and later a fusion operation was performed in Seattle by Dr. Roscoe Mosiman, an orthopedic specialist, with additional surgery later required to remove a herniated disc. In dealing with the causal relationship between Dr. Toothaker's initial treatment and the ultimate condition of the plaintiff, the court observed:

> It is axiomatic that to establish causation between the liability-producing situation and the claimed injuries or subsequent condition, the medical testimony must reasonably exclude, as a probability, every hypothesis other than the one relied

on to remove it from the realm of speculation or conjecture. *O'Donoghue v. Riggs*, 73 Wash2d 814, 824, 440 P.2d 823 (1968). The testimony must be sufficient to establish that the injury-producing situation "probably" or "more likely than not" caused the subsequent condition, rather than that the accident or injury "might have," "could have," or "possibly did" cause the subsequent condition. *Ugolini v. States Marine Lines*, 71 Wash2d 404, 407, 429 P.2d 213 (1967).

The medical testimony in this case achieved the required level of certainty to establish proximate causation between the failure of defendant to personally notify Dr. Hogberg of the serious x-ray implications and the complications which occurred because immobilization was not promptly accomplished.

At one point Dr. Mosiman testified: "so it's impossible for me to say whether or not the surgery would have been necessary although I feel it was *more likely* to be necessitated by not having the initial immobilization." (Italics ours.)

At another point this series of questions and answers was elicited from Dr. Mosiman:

> Q Was the prospect of that disc rupturing any greater on the 11th of March as opposed to the 23rd of February, with reasonable medical certainty?
>
> A I think you can say it is *much more likely*.
>
> . . . . . .
>
> Q With reasonable medical certainty, what were the probabilities that the disc would not have ruptured?
>
> A Well, let me understand this, if this boy had been treated in traction initially, and maintained in traction, then it would have been *much less likely* to have ruptured.
>
> Q That is with reasonable medical certainty?
>
> A Yes.

(Italics ours.) The fact that the doctor refused to testify in terms of absolute certainty and the fact that he acknowledged on cross-examination that the question was "iffy" may affect the weight of the testimony. It does not, however, nullify the opinion as set forth above.

> No medical opinion on a question of this kind is susceptible of scientific precision and there will always be an "iffy" element involved. However, if in the physician's expert judgment, the causal relationship is probable or more likely than not, the quality of the evidence rises above speculation and conjecture and may be considered by the trier of the fact. *Ugolini v. States Marine Lines, supra*. Read as a whole, Dr. Mosiman's testimony was sufficient to establish the necessary causal relationship.

Merriman, 515 P.2d at 512.

The question in this case centers around the statutory provision:

> (3) As a proximate result of the defendant's negligent act or omission, the plaintiff suffered injuries which would not otherwise have occurred.

Tenn.Code Ann.§ 29-26-115(a)(3).

While it is clear from Dr. Damp's deposition that he did not feel the need to consult with anyone to confirm his diagnosis of Ms. Waterman's compression fracture as chronic rather than acute *post* x-ray, he nevertheless relied on Dr. Stewart to take and read an x-ray which, according to Dr. Damp's treatment notes indicated a compression fracture of "indeterminate" age. Dr. Damp testified that although he felt competent generally to read x-rays, he felt that Dr. Stewart was more competent in the film reading. He testified that St. Thomas had on site other imaging modalities which could better determine the age of Ms. Waterman's fracture, but that he did not request them. Dr. Damp's own testimony, when viewed in a light most favorable to the plaintiff, demonstrated a genuine issue of material fact as to whether his conduct fell below the established standard of care for his patient. The doctor's own treatment notes indicated "possible old compression fracture." In his deposition he discussed the significance of this notation:

> Q. What did you mean by "possible old compression fracture?" did you mean it was possibly old or it's possibly a compression fracture?
> A. Possibly a compression fracture.
> Q. So at this point you weren't even sure if [it] was a compression fracture?
> A. I thought it most likely was, and based on the exam I thought it was old.
> Q. Okay. Did you feel the need to consult with anybody at this point to confirm – your diagnosis?
> A. No.
> Q. Do you have doctors at St. Thomas Hospital that you can consult with if you're uncertain of a diagnosis?
> A. We do.
> Q. Who would that be?
> A. Orthopaedists, I guess.

Earlier in deposition the Doctor was asked:

Q. If you're not sure or if you entertain any doubts about the age of a fracture, whatever – what other imaging modalities are there that might be more effective that might help you determine the age of the fracture?
A. CAT scan or MRI.
Q. Okay. An MRI would be better than a CAT scan?
A. It would.
Q. Okay. How about a bone scan?
A. Bone scan could be helpful.

Dr. Damp testified that he had never ordered a bone scan out of the emergency room, but that the MRI would probably be the first choice in determining the acuteness of a fracture Nevertheless, no MRI was requested.

Dr. Damp testified that missing an acute compression fracture could result in "intractable pain or spinal nerve or root injury." He acknowledged that other than his emergency medicine certification he held no specialized medical certification. At this point in the inquiry it bears noting that the trial court excluded Dr. Childs' affidavit only as to consideration of the standard of care for an emergency room physician. Dr. Childs however is qualified to testify as to the causal relationship between the defendant's alleged failure to refer and the injuries suffered. Nevertheless the defendant argues on appeal that allowing such testimony would violate the locality rule. Part and parcel of the duty to refer a patient is the fact that the referring physician lacks the requisite specialized knowledge to properly assess and treat an ailment. Establishing causation is an issue separate and apart from the standard of care. The proof before the trial court at the first summary judgment hearing included Dr. Childs Affidavit, in which he averred:

> If Dr. Peter Damp had treated Phebe Waterman within the recognized standard of care, he would have either obtained a consult from an orthopaedist or orthopaedic surgeon at St. Thomas Hospital or he would have immediately referred Phebe Waterman for further evaluation and treatment of her compression fractures. Earlier diagnosis would have allowed for treatment options such as vertebroplasty, kyphoplasty, and/or bracing designed to prevent collapse. If Phebe Waterman had received earlier appropriate treatment, then more likely than not, she would have had a substantially better outcome with greater mobility and less pain.

This Court's discussion in *Pullum v. Robinette* is especially illuminating:

> On appeal, Dr. Robinette argues that all of Dr. Neer's testimony as to causation should have been excluded because, as a dentist, Dr. Neer was not qualified to testify that any negligence by Dr. Robinette was the cause of Ms. Pullum's injuries. He contends that causation in this case was not within Dr. Neer's expertise and that only a neurologist or a neurosurgeon should be considered qualified to testify about a nerve injury.

The statutory test for expert testimony as to any of the elements required to recover for health care malpractice is whether the expert is licensed to practice and has practiced "a profession or specialty which would make the person's expert testimony relevant to the issues in the case." Tenn.Code Ann. § 29-16-115(a)(3). *Ledford*, 742 S.W.2d at 647.

Disputes over this requirement, and the cases resolving those disputes, have most often involved qualification to establish the standard of care and centered on the specialty involved. For example, in *Cardwell v. Bechtol*, 724 S.W.2d 739, 754 (Tenn.1987), the Court held that, although there is no requirement that the expert practice in the same specialty, the witness must be sufficiently familiar with the standard of the profession or specialty to be able to give relevant testimony. In that case, an orthopedic specialist admitted he was not familiar with the practice and types of treatment administered by osteopaths such as the defendant. While a neurologist attempted to testify as to the osteopath's standard of care in two areas, he also conceded he had no training in the field and was unfamiliar with the standard of care of the profession of osteopathy. Consequently, neither expert could render a relevant opinion on standard of care. *Id.* at 752; see also, e.g., *Searle v. Bryant*, 713 S.W.2d 62 (Tenn.1986) (finding an infectious disease specialist/clinical microbiologist was qualified to testify about the standards of care applicable to surgeons for the preventions and treatment of surgical wound infections because his training and specific practice or experience made his testimony relevant to those issues); *Ledford*, 742 S.W.2d at 647-48 (holding in an action against a psychiatrist that a neurologist who was also board certified in psychiatry was competent to testify as to the standard of care because his testimony regarding his training and specific experience made his testimony relevant to the issues).

The issue here, however, is not standard of care; it is causation. Dr. Robinette's argument is that Dr. Neer's training and experience as a dentist do not qualify him to testify as to the cause of nerve damage. He asserts this is a medical (presumably, as opposed to a dental) question.

Courts have in some cases held that certain professions are not qualified to render medical opinions. Several of those cases have held that the testimony of nurses, who are prohibited by statute from making medical diagnoses, could not establish medical causation. *See Richberger v. The West Clinic, P.C.*, 152 S.W.3d 505 (Tenn.Ct.App. 2004) (no *143Tenn. R.App. P. 11 application filed) (discussing previous cases involving causation testimony by nurses).

Dr. Robinette relies primarily on *American Enka v. Sutton*, 216 Tenn. 228, 391 S.W.2d 643 (1965), a workers' compensation case. The question in that case was whether the testimony of the injured worker and an optometrist were "of sufficient probative value to establish a causal connection between the accident [acid was splashed in the worker's eye] and the loss of eyesight" in contradiction to the

> testimony of an ophthalmologist who testified there could be no possible connection between the accident and the specific neuritic condition of the worker. *Id.* at 645. The court answered the question negatively and found that the optometrist's testimony could not be considered material evidence on the issue. That conclusion was based upon the fact that the optometrist's training was in the field of measuring vision and fitting lenses. His training and profession did not qualify him as a medical expert in diseases of the eye. That deficiency was relevant because the ophthalmologist, who was trained in the treatment of diseases of the eye, had testified that the worker's loss of sight was due to optic neuritis, an inflammation of the optic nerve.
>
> We do not agree that Dr. Neer's testimony as to causation should have been excluded. It appears to us that by training and experience, Dr. Neer is qualified to testify as to the types of nerve damage that can result from negligently performed dental procedures. Dr. Neer testified that learning about the nerves in the face and head was part of his dental training. He stated, "We're taught where the nerves are, where they exit, what anatomical structures are in the area, what procedures are likely to damage nerves, and we're taught how to take the necessary precautions not to do that." He exhibited his knowledge of how nerves function and how anesthesia, administered by dentists, affects that functioning. While a dentist such as Dr. Neer may not be able to explain precisely why a nerve probed by an instrument is damaged, he was competent to testify that such damage occurs. Any deficiencies in his knowledge of the scientific basis for the working of nerves go to the weight of his testimony. We find Dr. Neer's testimony on causation sufficient to establish that element.

*Pullum v. Robinette,*174 S.W.3d 124, 142-43 (Tenn. Ct. App. 2004).

In *Delisi v. St. Luke's Episcopal-Presbyterian Hosp., Inc.*, 701 S.W.2d 170 (Mo.Ct.App.1985), the court held that the defendant doctor's own testimony was sufficient for the case to go to the jury on the issue of breach of the standard of care but that neither the plaintiff's expert testimony nor the testimony of the defendant was sufficient as to causation.

The affidavit of Dr. Childs considered under principles laid down in *Pullum* is sufficient to present the issue of causation to the trier of fact. *See Jacobs v. Flynn*, 749 A.2d 174 (Md.2000).

On the record before us, Dr. Childs' testimony on the treatment options foregone as a result of Dr. Damp's alleged failure to properly refer his patient would assist the trier of fact in determining whether the injury suffered was caused more likely than not by the defendant's negligent act. *See Bara v. Clarksville Mem. Health Systems*, 104 S.W.3d 1, 8 (Tenn. Ct. App. 2002); *see also Kilpatrick v. Bryant*, 868 S.W.2d 594, 598 (Tenn. 1993). In the case before us, Dr. Damp's own testimony establishes a genuine issue of material fact as to the applicable standard of care, and Dr. Childs establishes a genuine issue of fact as to causation making summary judgment improper at this time.

IV. THE CONCLUSION

The discussion of the issues in this case is entirely in the context of summary judgment and the mandate under Tennessee Rule of Civil Procedure 56 that the evidence must by construed in the light most favorable to the non-moving party. Since no proof has been offered that would create a material fact issue as to the vicarious liability of St. Thomas Hospital relative either to Dr. Damp or Dr. Stewart, summary judgment must be entered in favor of St. Thomas Hospital. The action of the trial court in granting summary judgment to Dr. Damp is reversed and the case remanded for further proceedings. Costs of this cause as it relates to St. Thomas Hospital are assessed to Appellant. Costs of this cause as it relates to the appellee, Dr. Damp, are assessed to Dr. Damp.

_____

WILLIAM B. CAIN, JUDGE